

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12942

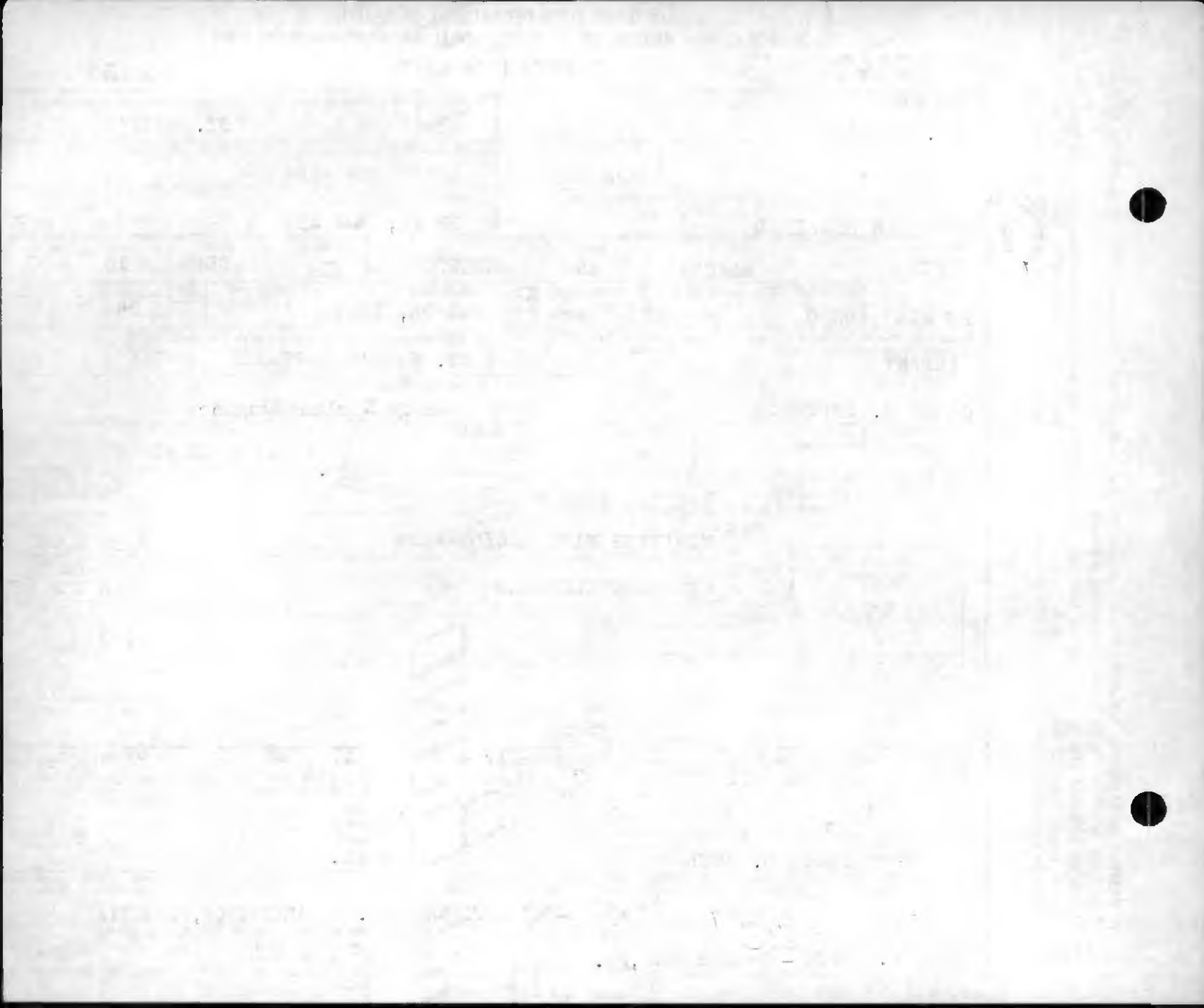
CERTIFICATE OF DEATH

12951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			
a. COUNTY ST. MARY'S		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATUXENT RIVER		c. LENGTH OF STAY IN 1b 22 DAYS		d. STREET ADDRESS RT #1, BOX 154	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
f. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STATION HOSPITAL							
g. NAME OF DECEASED (Type or print) First ALICIA Middle ANN Last ANDERSON				4. DATE OF DEATH Month SEPT Day 18 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 26, 1967		9. AGE (In years lost birthday) yrs. 24	IF UNDER 1 YEAR Months 24	IF UNDER 24 HRS. Hours 24 Min. 18-1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES A. ANDERSON				14. MOTHER'S MAIDEN NAME Emily Lorine Caughorn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address SAME AS #2 MOTHER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) VOMITING WITH DEHYDRATION DUE TO (c) MENINGOMYELOCOELE						INTERVAL BETWEEN ONSET AND DEATH 36 HOURS BIRTH TO 18 SEP 67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 SEP , 19 67 , to 18 SEP , 19 67 , that (I) (we) last saw the deceased alive on 18 SEP , 19 67 , and that death occurred at 0305 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>James R. Abel</i>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) James R. ABEL	
22d. ADDRESS Same as #1.				22e. ADDRESS Same as #1.		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/21/67		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR <i>John M. Welch</i> JOHN M. WELCH - LEONARDTOWN, MD.				25a. REC'D BY REGISTRAR DATE SEP 22 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1-271592



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14443

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VALLEY LEE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) BARBARA ANN DAILEY		4. DATE OF DEATH Month SEPTEMBER Day 30 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 18, 1967
9. AGE (In years lost birthday) yrs. 6 Months 12 Days 12 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE DAILEY		14. MOTHER'S MAIDEN NAME MARY CATHERINE GREENWEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT FATHER		18. SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7950 IMMEDIATE CAUSE (a) (SD11) DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.D. Boyd MD		22. DATE SIGNED OCTOBER 1, 67	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 2, 1967	
23c. NAME OF CEMETERY OR CREMATORY BETHESDA CEMETERY		23d. LOCATION (City or town) (County) (State) VALLEY LEE, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		ADDRESS LEONARDTOWN, MARYLAND	
25a. REC'D BY REGISTRAR OCT 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

144

ST. MARY'S

MARYLAND

ST. MARY'S

VALLEY LEE

LIFE

VALLEY LEE

27

30

SEPTEMBER

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MARCH 16, 1957

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1957

MARYLAND

MARY CATHERINE GREENWELL

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FATHER

(1957)

OCTOBER 1957

WILLIAM B. DUDLEY

VALLEY LEE, ST. MARY'S

BETHENNA GEMETRY

OCT. 1957

EMILE

W. CLARK MATTI VALLEY LEONARDTOWN, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12944

12952

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS RT. 2 GOLDEN BEACH	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES LEROY DOOLEY		4. DATE OF DEATH Month Day Year SEPTEMBER 13, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1906
9. AGE (In years lost birthday) yrs. 60		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CIVIA SERVICE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT L. DOOLEY		14. MOTHER'S MAIDEN NAME STELLA C. BOSTIC	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-10-8407	
17. INFORMANT Helen V. Dooley (Wife)		Address 3712 Andover Place S Washington, DC.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic HD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M.D.		22. DATE SIGNED 9/13/67	
EXAMINER'S NAME (Type) WILLIAM D. BOYD M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Sept. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) Suitland, Maryland
24. FUNERAL DIRECTOR Simmons Bros. - 1661-Gd. Hope RD. SE. Wash., DC		25a. REC'D BY REGISTRAR SEP 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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Environ Biol Fish (2008) 81:239–247

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

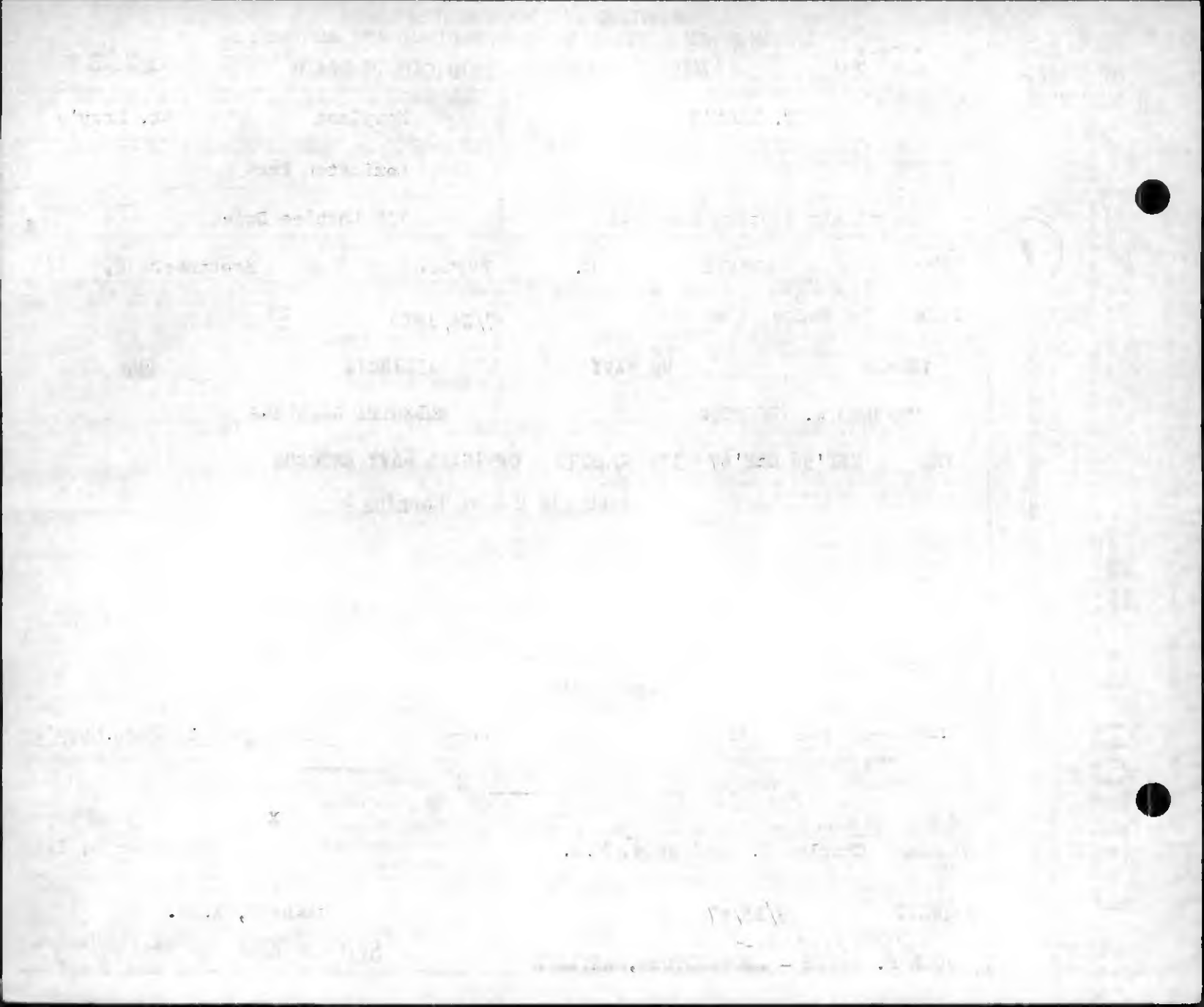
12953

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Air Station Hospital				d. STREET ADDRESS 259 Chinlee Drive			
3. NAME OF DECEASED (Type or print) First MELVIN Middle C. Last DUNCAN				4. DATE OF DEATH Month September Day 8, Year 1967			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/24/1939	9. AGE (In years last birthday) 28 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) YEOMAN		10b. KIND OF BUSINESS OR INDUSTRY US NAVY		11. BIRTHPLACE (State or foreign country) ILLINOIS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES W. THOMPSON				14. MOTHER'S MAIDEN NAME ROBERTHA MEADERDS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES SEP '56 SEP '67		16. SOCIAL SECURITY NO. 338 30 8770		17. INFORMANT OFFICIAL NAVY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to hanging 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Hanged self					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:50 XXXX 9-8 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Lexington Park St. Mary's	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED September 8, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 9/13/67		23c. NAME OF CEMETERY OR CREMATORY JOHN M. WELCH - LEONARDTOWN, MARYLAND		23d. LOCATION (City or Town) (County) (State) OAKLAND, CALIF.	
24. FUNERAL DIRECTOR JOHN M. WELCH				25a. REC'D BY REGISTRAR DATE SEP 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

ADDRESS
JOHN M. WELCH - LEONARDTOWN, MARYLAND

25a. REC'D BY REGISTRAR
DATE **SEP 15 1967**

25b. REGISTRAR'S SIGNATURE
Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12946

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12954

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VALLEY LEE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANDOVER ESTATES				d. STREET ADDRESS ANDOVER ESTATE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HERBERT Middle TOM Last GIDDINGS				4. DATE OF DEATH Month SEPTEMBER Day 13 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1901	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME TOM GIDDINGS				14. MOTHER'S MAIDEN NAME SARAH ANN GIDDINGS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-12-3466		17. INFORMANT LOUIE ELIZABETH GIDDINGS Address SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 13 Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1967 , to Sept 13 1967 , that (I) (we) last saw the deceased alive on Sept. 13 1967 , and that death occurred at 12:11 from causes and on the date stated above.							
22a. SIGNATURE W.H. Patrick				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-14-67	
22c. PHYSICIAN'S NAME (Type) WILLIAM H. PATRICK M. D.				22d. ADDRESS LEXINGTON PARK, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 15, 1967		23c. NAME OF CEMETERY OR REMOVAL ST. GEORGE EPISCOPAL		23d. LOCATION (City or Town) (County) (State) VALLEY LEE, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

STATE OF NEW YORK
IN SENATE
January 1, 1902
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899
ALBANY: J.B. LEECH, STATE PRINTER.
1902.

ALBANY: J.B. LEECH, STATE PRINTER.
1902.

FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

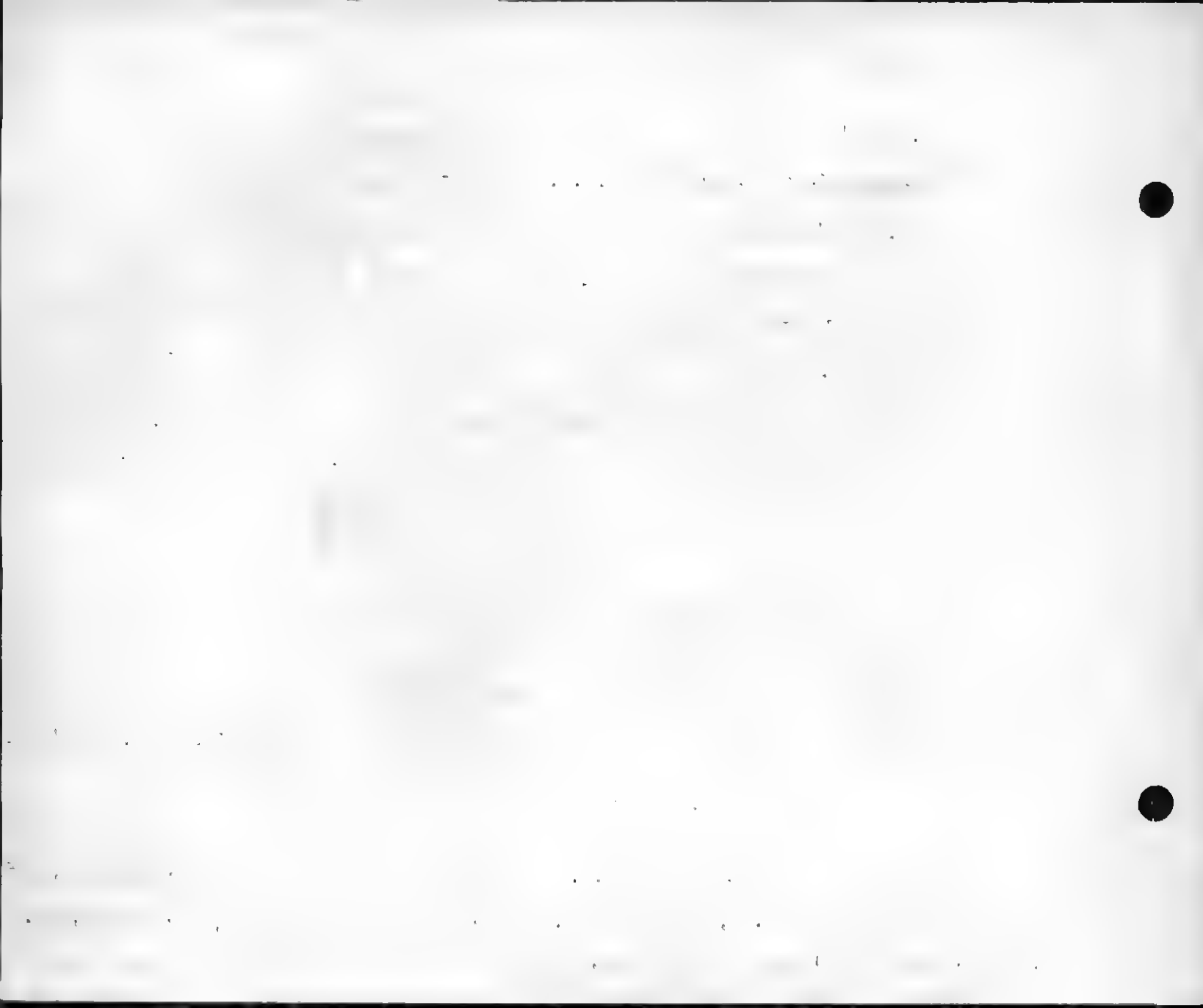
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1284

12855

1 PLACE OF DEATH a COUNTY St. Mary's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN D.O.A. c LENGTH OF STAY in 1b 1 d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY St. Mary's c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown d STREET ADDRESS Leonardtown, Maryland e RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES A. HEBB		4 DATE OF DEATH Month Sept. Day 9 Year 1967	
5 SEX Male	6 COLOR OR RACE Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/23/1947
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmington		10b KIND OF BUSINESS OR INDUSTRY —	11 BIRTHPLACE (State or foreign country) MD
13 FATHER'S NAME Charles Ignatius Hebb		14 MOTHER'S MAIDEN NAME Flora Louise Barber	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16 SOCIAL SECURITY NO. —	17 INFORMANT Charles I. Hebb, Leonardtown
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO (c) —			19 INTERVAL BETWEEN ONSET AND DEATH —
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subject was struck by auto			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Subject was struck by auto	
20c TIME OF INJURY Month, Day, Year Hour a.m. 4:30 a.m. 9 9 1967	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Street	20f (City or town) (County) (State) Loveville St. Mary's Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED September 10, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county) St. Aloysius Leonardtown, St. Mary's, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF SEPT. 12, 1967	23c NAME OF CEMETERY OR CREMATORY St. Aloysius	23d LOCATION (City or town) (County) (State) Leonardtown, St. Mary's, Md.
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25a REC'D BY REGISTRAR SEP 13 1967	25b REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

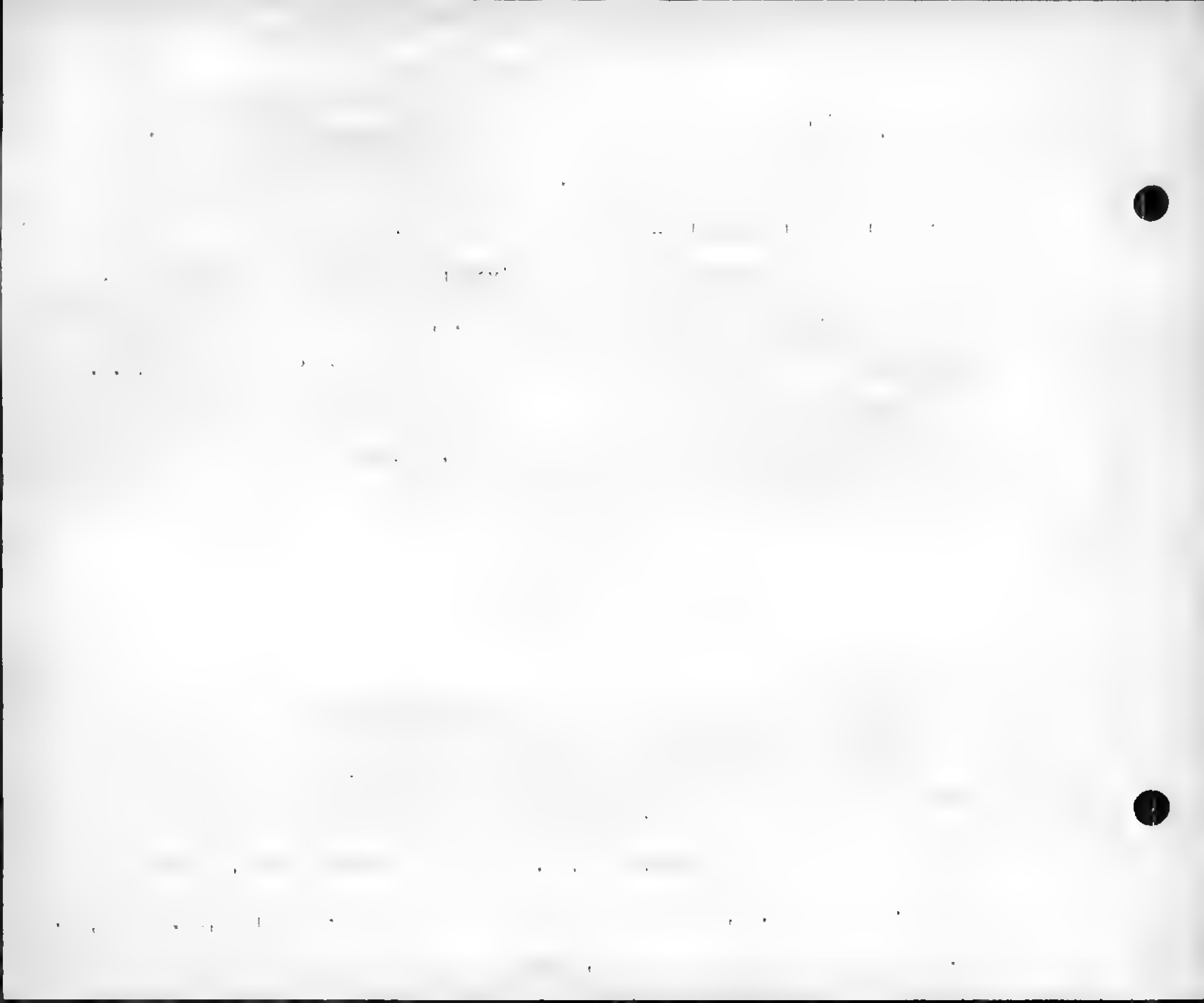
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12845

12956

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PATUXENT RIVER		c. LENGTH OF STAY IN IB 1 1/2 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NAVAL AIR STATION HOSPITAL		d. STREET ADDRESS RT 1 Box 37	
3 NAME OF DECEASED (Type or print) First JOHN Middle IVANCIK Last IVANCIK		4. DATE OF DEATH Month SEPTEMBER Day 14 Year 1967	
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 4, 1886
9. AGE (In years lost birthday) 81 yrs		10. IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CABINET MAKER	
11. BIRTHPLACE (County & State, or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME MICHAEL IVANCIK		14 MOTHER'S MAIDEN NAME MAGDALENE FACCATE	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. JOHN R. IVANCIK	
17 INFORMANT JOHN R. IVANCIK		Address SAME AS # 2 ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerosis, coronary artery. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Sclerosis (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June, 1967 to Sept. 1967 that (I) (we) last saw the deceased alive on Sept 8, 1967 , and that death occurred at 6:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Michael Barbarich		22b DATE SIGNED 9.15.67	
22c. PHYSICIAN'S NAME (Type) MICHAEL BARBARICH M. D.		22d ADDRESS LEONARDTOWN, MD. LEXINGTON PARK, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE THEREOF SEPT. 18, 1967	23c NAME OF CEMETERY OR CREMATORY HOLY FACE CEMETERY	23d LOCATION (City or Town) (County) (State) GREAT MILLS ST. MARY'S, MD.
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a REC'D BY REGISTRAR SEP 19 1967	
ADDRESS LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

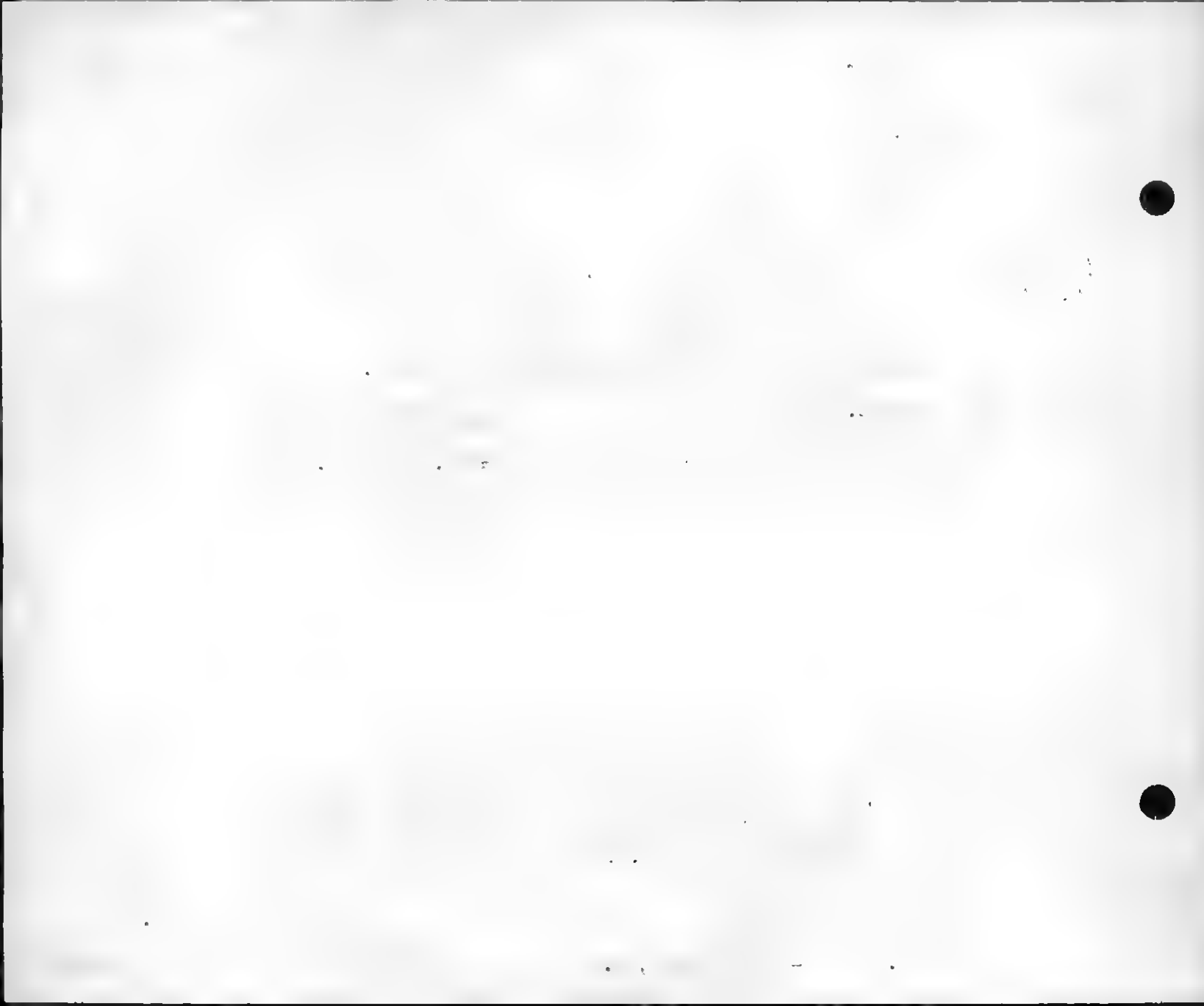
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12945

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12957

1 PLACE OF DEATH a COUNTY St. Mary's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY St.	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b Patuxent River	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		d STREET ADDRESS Box 222	
3 NAME OF DECEASED (Type or print) First JOHN Middle F. Last IVERY, SR		4 DATE Month September Day 13 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 11/26/1901
9 AGE (In years last birthday) 65 yrs		10 IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min 65	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b KIND OF BUSINESS OR INDUSTRY AUTO PARTS(SALES)	
11 BIRTHPLACE (State or foreign country) PENNA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN M. IVERY		14. MOTHER'S MAIDEN NAME MARY JANE BAKER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 167 03 3771	
17 INFORMANT JOHN F. IVERY JR.		Address SAME AS #2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Arteriosclerotic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		22. DATE SIGNED 9/14/67	
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, TRANSIT, or REMOVAL (Specify) TRANSIT	23b. DATE THEREOF 9/14/67	23c. NAME OF CEMETERY OR CREMATORY BEAVER, PENNA.	
23d. LOCALITY (City or Town) (County) (State) LEONARDTOWN, MD.		23e. REC'D BY REG STRAR SEP 18 1967	
23f. REG STRAR'S SIGNATURE Charles Judge		23g. REG STRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT5 (4)
25M 1/67

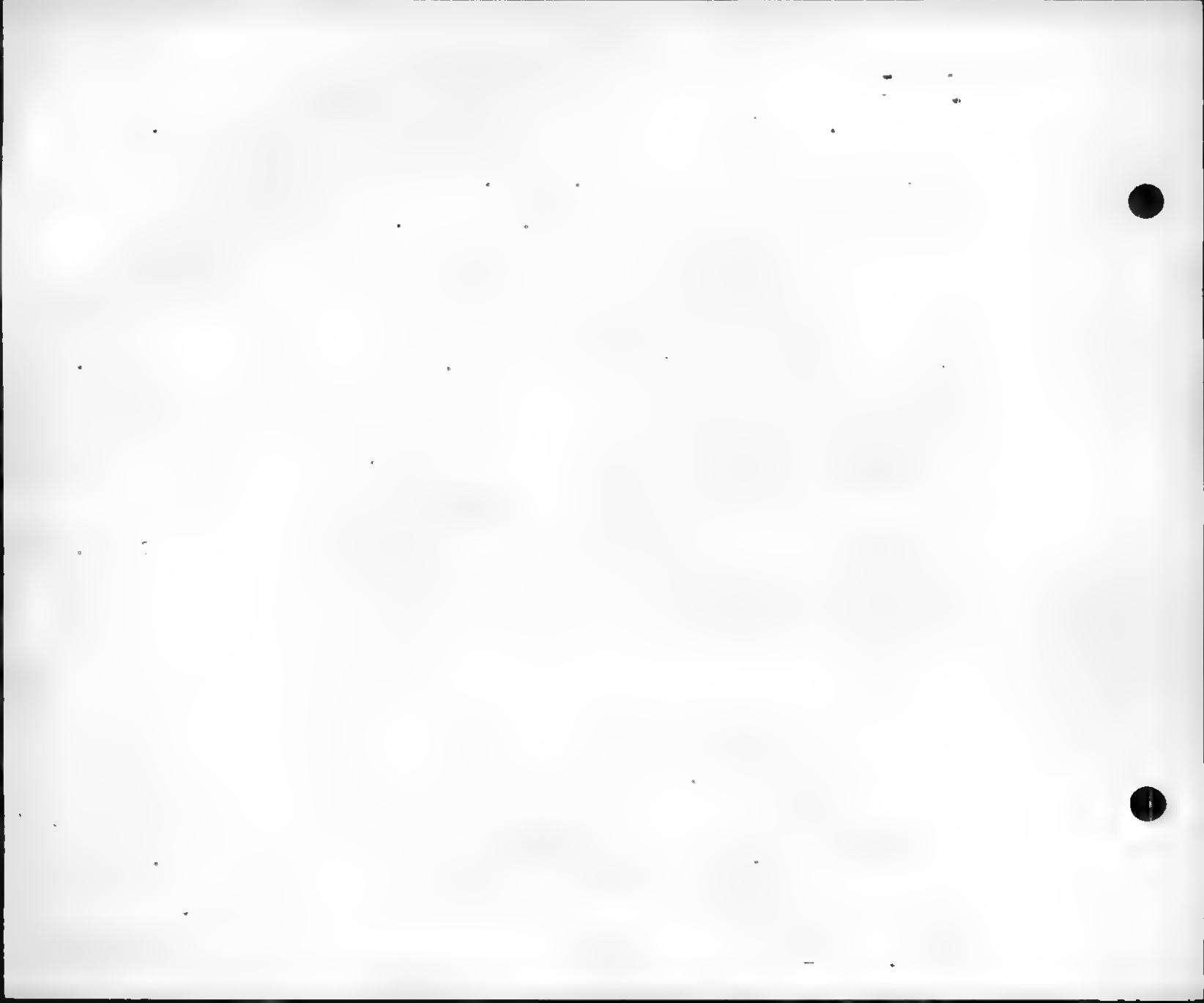
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12958

12950

CERTIFICATE OF DEATH

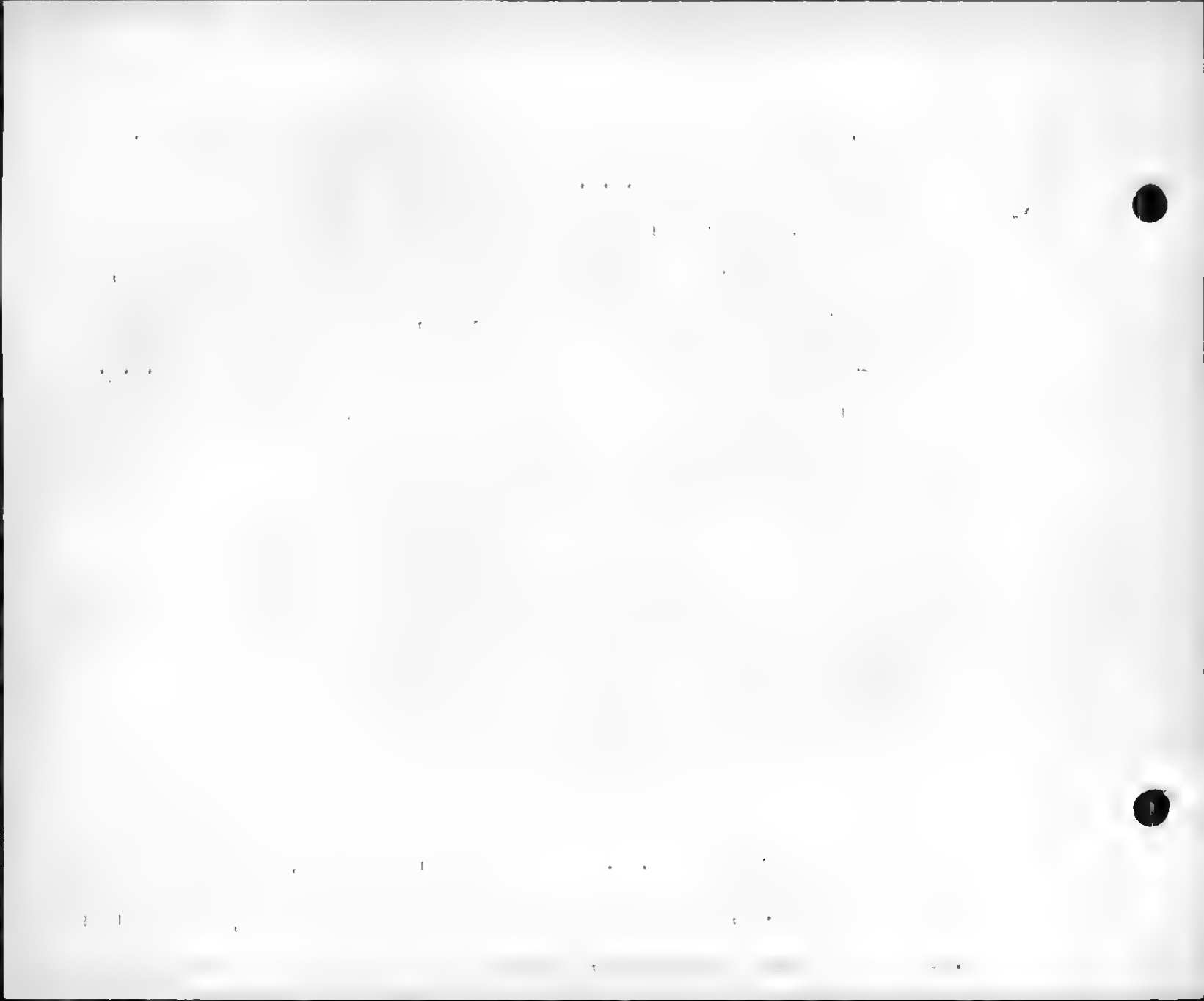
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NAS, Patuxent River		c. LENGTH OF STAY IN 1b 11 hrs. 20 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Station Hospital, USNAS, Patuxent River			d. STREET ADDRESS 33 E. Rennell Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Joseph Last Lupi			4. DATE OF DEATH Month September Day 5 Year 1967		
5. SEX male	6. COLOR OR RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 5, 1967		9. AGE (In years last birthday) yrs 11 Months 11 Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not applicable		10b. KIND OF BUSINESS OR INDUSTRY Not applicable		11. BIRTHPLACE (County & State, or foreign country) St. Mary's, Maryland	
13. FATHER'S NAME Sebastian Anthony Lupi			14. MOTHER'S MAIDEN NAME Sandra Lee Nemeth		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NA NA NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT Official U. S. Navy Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline membrane disease 1150 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 11 hrs. 20 Min					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 5 1967 , to Sept. 5, 1967 , that (I) (we) just saw the deceased alive on Sept. 5, 1967 , and that death occurred at 3:15 P M, from causes and on the date stated above					
22a. SIGNATURE <i>James R. Abel</i>			22b. DATE SIGNED September 5, 1967		22c. PHYSICIAN'S NAME (Type) JAMES R. ABEL, LT, MC, USN
22d. ADDRESS USNAS, Patuxent River, Md. 20670			22e. ADDRESS USNAS, Patuxent River, Md. 20670		
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANSIT		23b. DATE THEREOF 9/7/67		23c. NAME OF CEMETERY OR CREMATORY EASTON, PENNA.	
23d. LOCATION (City or town) (County) (State) EASTON, PENNA.		23e. LOCATION (City or town) (County) (State) EASTON, PENNA.		23f. LOCATION (City or town) (County) (State) EASTON, PENNA.	
24. FUNERAL DIRECTOR <i>John M. Welch</i>		24b. ADDRESS JOHN M. WELCH - LEONARDTOWN, MARYLAND		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

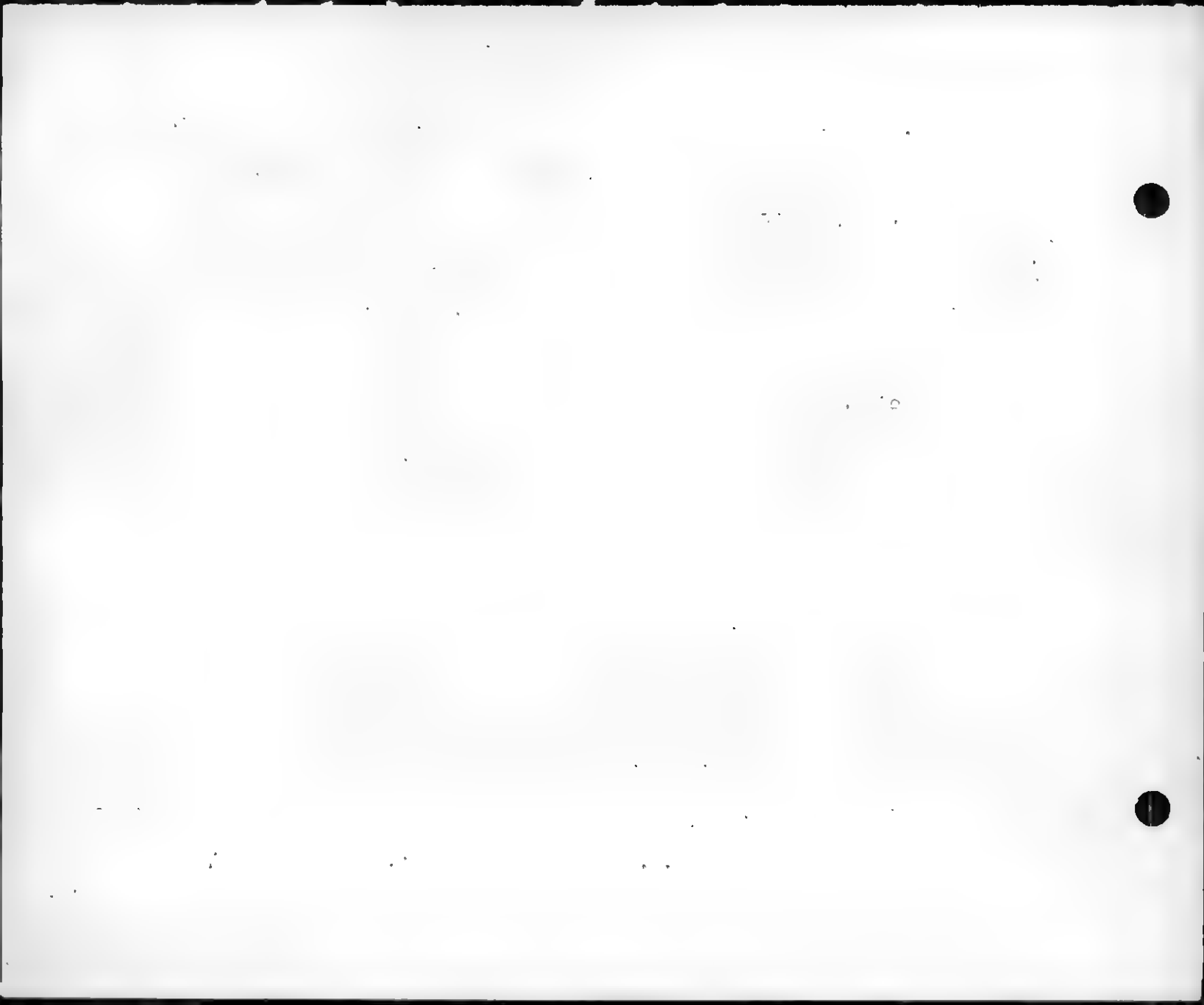
<div style="display: flex; justify-content: space-between;"> <div> 12951 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 7 Film 3-39-67 JK </div> <div> CERTIFICATE OF DEATH </div> <div> 12959 </div> </div>											
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEXINGTON PARK					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PATUXENT RIVER NAVAL AIR STATION HOSPITAL						d. STREET ADDRESS Rt 1 Box 145 B				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANKLIN EMERY McBEE						4. DATE OF DEATH Month Day Year SEPTEMBER 21, 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 29, 1895		9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) PAPER MILL				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM McBEE						14. MOTHER'S MAIDEN NAME MARY CATHERINE BROWNFIELD					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW I				16. SOCIAL SECURITY NO.		17. INFORMANT Address NORMAN PHILLIPS SAME AS # 2 ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) with metastases lost (c) Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1966 to Apr 21, 1967 , that (I) (we) last saw the deceased alive on Apr 21, 1967 , and that death occurred at 11:10 A.M. from causes and on the date stated above.											
22a. SIGNATURE Juanito Roa M.D.						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JUANITO ROA M. D.			
22d. ADDRESS LEXINGTON PARK, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 25, 1967		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				23d. LOCATION (City or Town) (County) (State) COVINGTON, VIRGINIA			
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND						25a. REC'D BY REGISTRAR SEP 25 1967		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u> c. LENGTH OF STAY IN 1b <u>47 Minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Mary's Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural California, Md.</u> d. STREET ADDRESS <u>Box 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Moses</u>				4. DATE OF DEATH Month <u>September</u> Day <u>16</u> Year <u>1967</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1967</u>		9. AGE (In years last birthday) <u>—</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>47</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael A. Moses</u>						14. MOTHER'S MAIDEN NAME <u>Mary Reeves</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Box 2 California, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal apnea</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized anasarca</u>										INTERVAL BETWEEN ONSET AND DEATH <u>47 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 16, 1967</u> , to <u>Sept 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 16, 1967</u> , and that death occurred at <u>7:40 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Leon Berube</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-16-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Leon Berube, M.D.</u>						22d. ADDRESS <u>Mechanicville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>All Saints</u>		23d. LOCATION (City, town or county) (State) <u>Lookoy, Md.</u>			
24. FUNERAL DIRECTOR <u>W. C. Mattingley Leonardtown, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



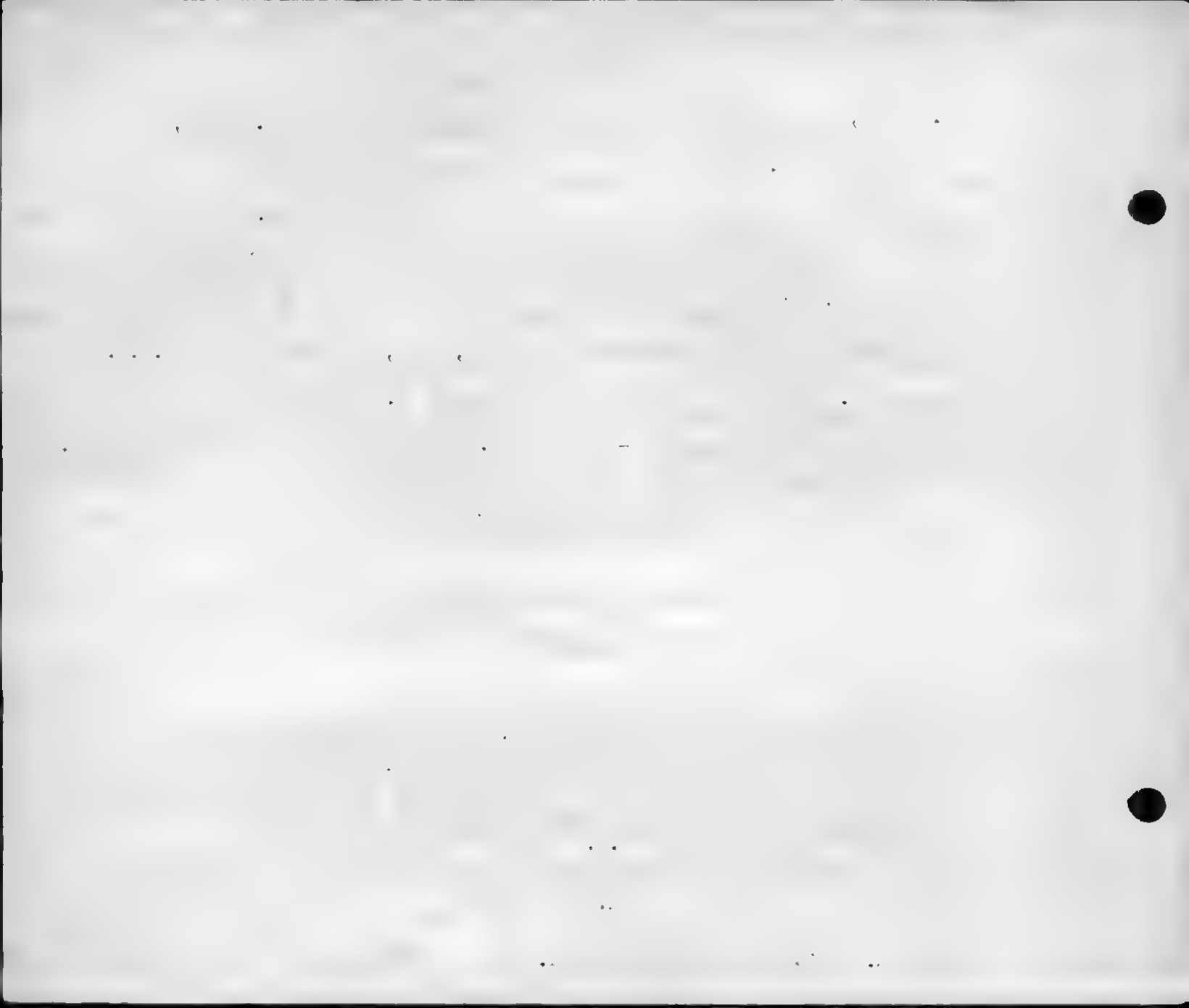
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 12961

12953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ST. MARY, S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND				b. COUNTY ST. MARY, S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN Md.				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LEONARDTOWN MARYLAND				d. STREET ADDRESS LEONARDTOWN Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEILA CATHERINE NORRIS				4. DATE OF DEATH Month SEPTEMBER Day 28 Year 1967							
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/11/1877		9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC				11. BIRTHPLACE (County & State, or foreign country) ST. MARY, S MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOHN T. YATES				14. MOTHER'S MAIDEN NAME LUCY M. CLARKE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 212-56-0154J1				17. INFORMANT J. RICHARD NORRIS Address LEONARDTOWN Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 4. 2. 1. DUE TO (b) Cardio Vascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/11 19 60 to Sept 28 19 67 that (I) (we) last saw the deceased alive on Sept 27 19 67 , and that death occurred at 5:30 from the causes and on the date stated above.											
22a. SIGNATURE Charles Greenwell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 9/29/67			
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M.D.				22d. ADDRESS LEONARDTOWN MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 9/30/1967		23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS		23d. LOCATION (City, town or county) (State) LEONARDTOWN MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Welch				ADDRESS LEONARDTOWN Md.				25a. REC'D BY REGISTRAR DATE OCT 3 1967			
								25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

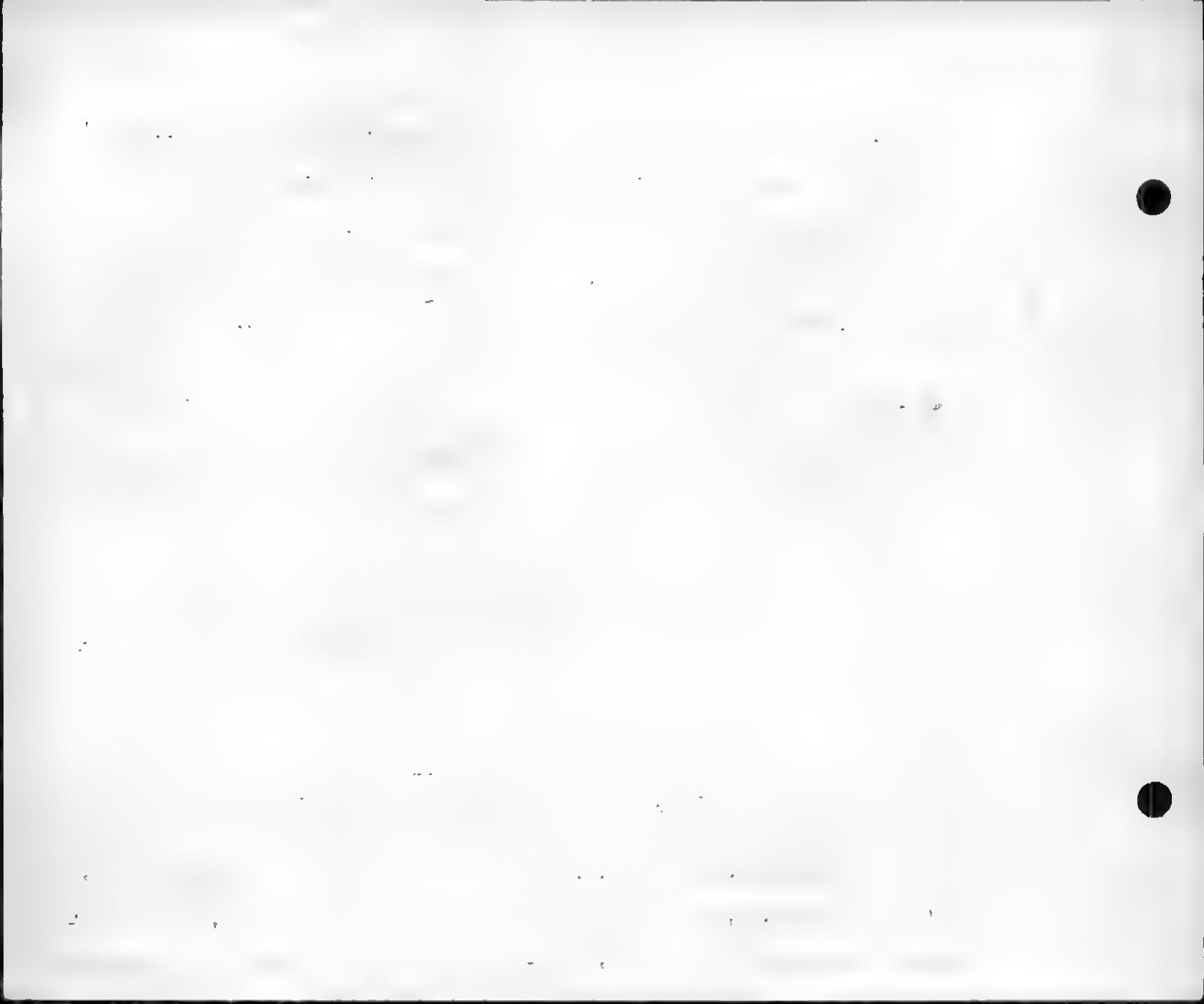
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12954

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12962

1 PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
c. LENGTH OF STAY in 1b Life		d. STREET ADDRESS 227 Chinlee Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 227 Chinlee Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last RICHARD M. OWEN		4 DATE OF DEATH Month Day Year September 8 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6/15/67
9 AGE (In years, lost birthday) 23 mo.		10 IF UNDER 1 YEAR Months Days Hours Min 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Richard H. Owen		14 MOTHER'S MAIDEN NAME Sharon Welles	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO —	
17 INFORMANT MOTHER		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SDII DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED September 8, 1967	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 10, 1967	23c. NAME OF CEMETERY OR CREMATORY JOY CHAPEL CEMETERY	23d. LOCATION (City or town) (County) (State) HOLLYWOOD, MARYLAND
24 FUNERAL DIRECTOR W. CLARKE MATTINGLEY		25a. REC'D BY REGISTRAR SEP 13 1967	
LEONARDTOWN, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12963

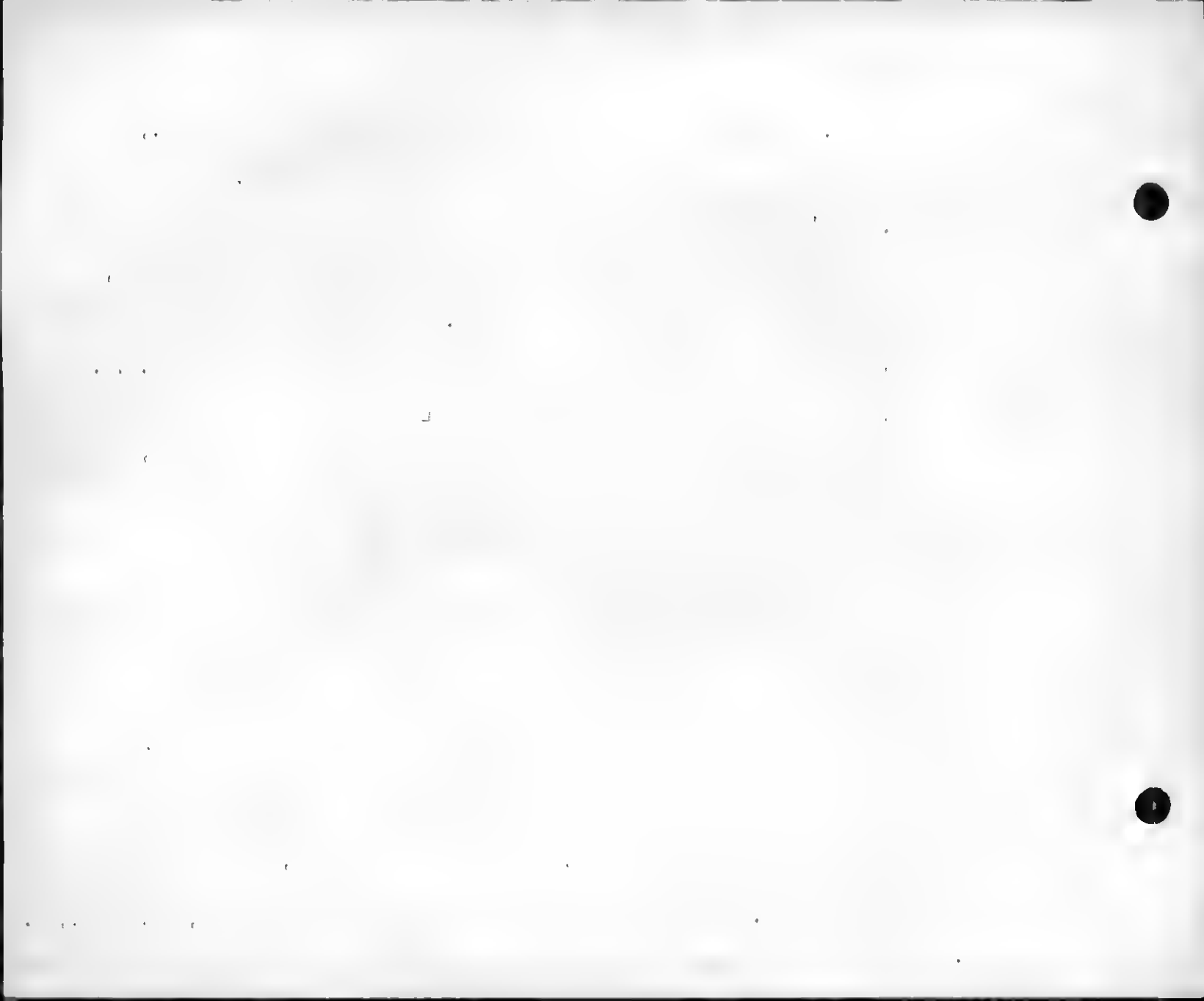
12955

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN, 181 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last JOHN HENRY PRICE			4 DATE OF DEATH Month Day Year SEPTEMBER 11 19 67				
5 SEX MALE	6. COLOR OR RACE NERGO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1880	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11 BIRTHPLACE (County & State, or foreign country) U.S.A.			
13. FATHER'S NAME CYRIA BROWN			14. MOTHER'S MAIDEN NAME ELLEN PRICE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address ANNIE FLORINE PRICE LEONARDTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac failure</u> (b) <u>Cardio vascular disease</u> (c) <u>Cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>63</u> , to <u>Sept 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 11</u> , 19 <u>67</u> , and that death occurred at <u>10 P.</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Charles Greenwell</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 14, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. ALOYSIUS CEMETERY	23d. LOCATION (City or Town) (County) (State) LEONARDTOWN, ST. MARY'S, MD.				
24. FUNERAL DIRECTOR ADDRESS W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>SEP 14 1967</u>							



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

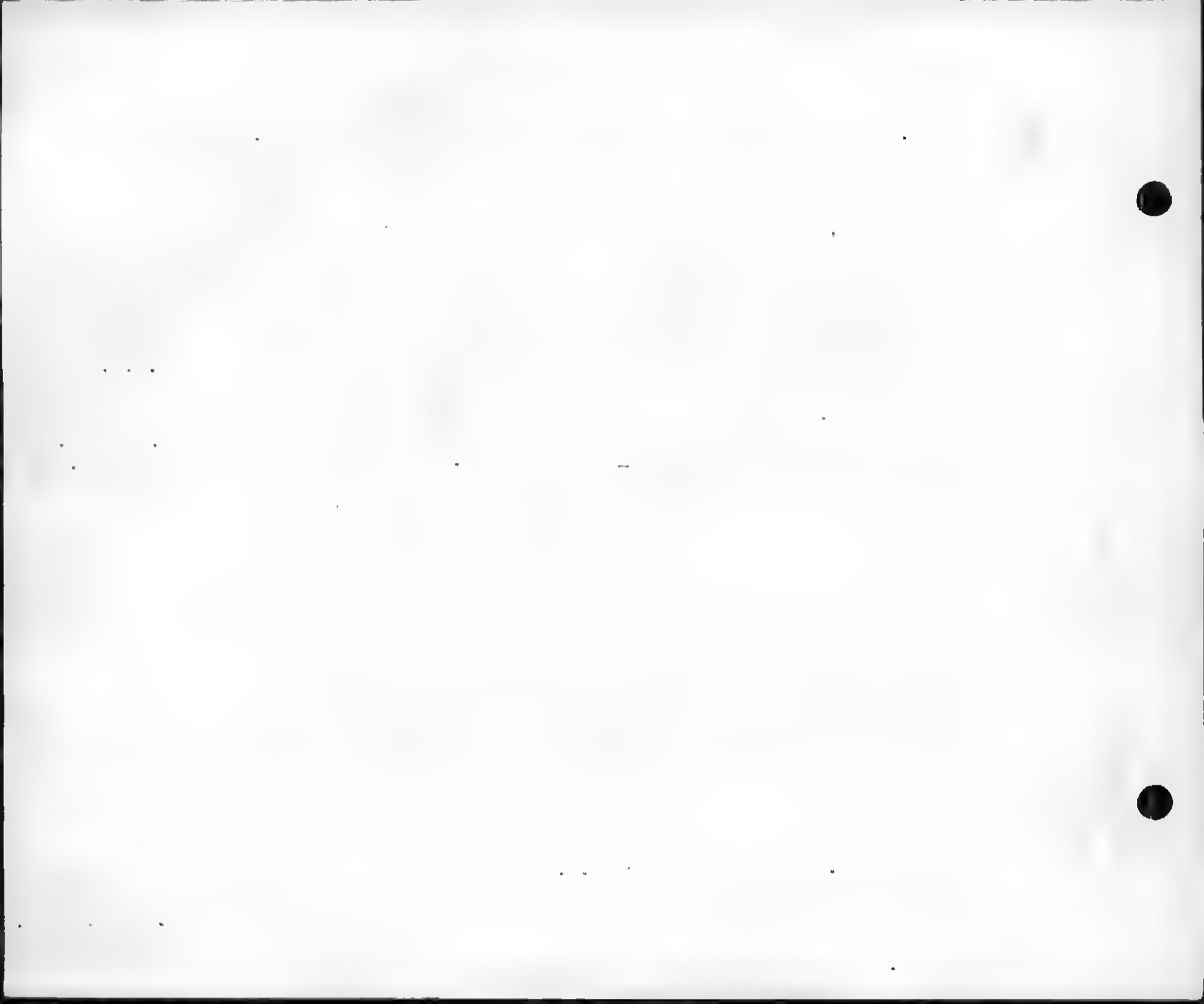
12956

12964

1 PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ST. MARY'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CALLAWAY MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL		d. STREET ADDRESS CALLAWAY MARYLAND		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) JOHN HERBERT PRICE		4 DATE OF DEATH Month SEPTEMBER Day 29 Year 1967			
5. SEX MALE	6 COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/3/1883	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM OWNER		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN A. PRICE		14. MOTHER'S MAIDEN NAME ROSA ANN WHEATLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-54-0859-T		17. INFORMANT MRS. CORINNE MILLER	
18 CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)		Circulatory Collapse Chronic Hemiparesis		INTERVAL BETWEEN ONSET AND DEATH 1 day yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 9/29/1967 to 9/29/1967 that (I) (we) last saw the deceased alive on 9/29/1967 and that death occurred at 9/29/1967 M, from causes and on the date stated above.					
22a. SIGNATURE J. P. Jarboe		22b. DATE SIGNED 9/29/1967		22c. PHYSICIAN'S NAME (Type) J. PATRICK JARBOE M.D.	
22d. ADDRESS GREAT MILLS MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/2/1967		23c. NAME OF CEMETERY OR CREMATORY HOLY FACE	
23d. LOCATION (City or Town) GREAT MILLS ST. MARY'S Md.		(County)		(State)	
24 FUNERAL DIRECTOR JOHN N. WELCH		25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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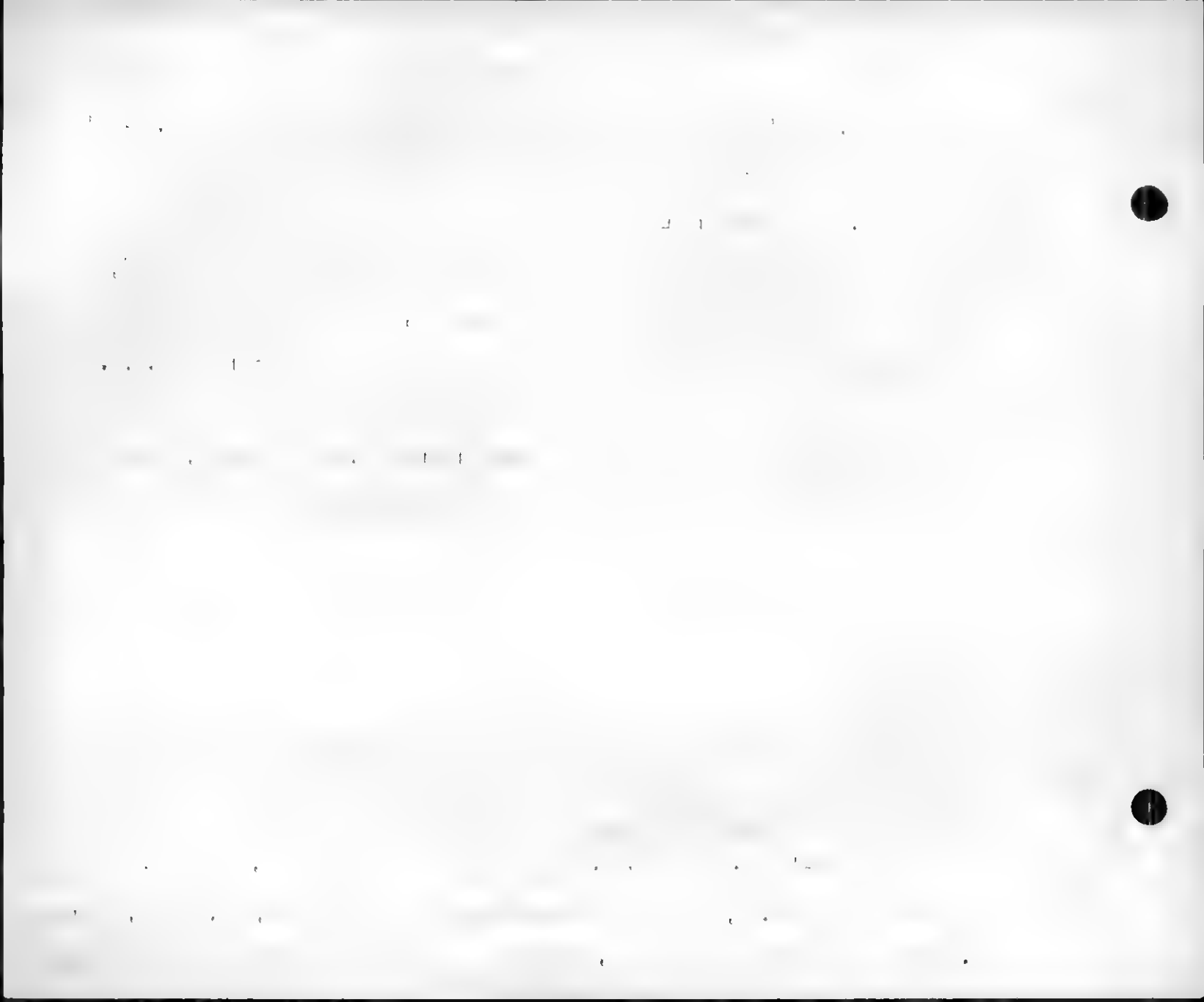
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12955

12965

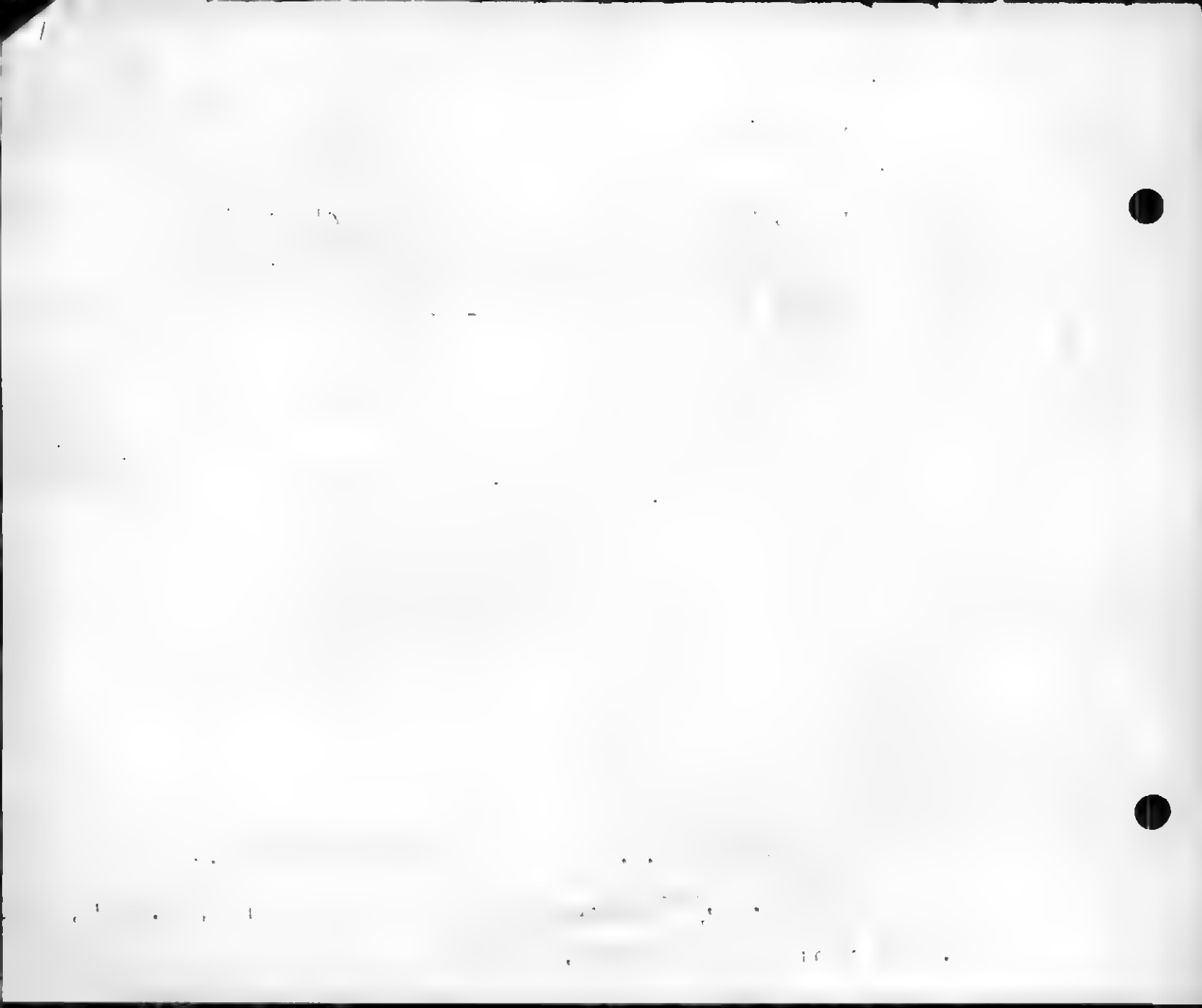
1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN				c. LENGTH OF STAY IN 1b 13 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS RURAL AVENUE			
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last RAGAN				4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1897	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT MRS VIRGINIA R. RALEY Address AVENUE, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 471X IMMEDIATE CAUSE (a) aspiration pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 13 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14 , 1967, to 9/24 , 1967, that (I) (we) last saw the deceased alive on 9/23 , 1967, and that death occurred at 7 M, from causes and on the date stated above.							
22a. SIGNATURE William D. Boyd				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM D. BOYD M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 27, 1967		23c. NAME OF CEMETERY OR CREMATORY ALL SAINTS CEMETERY		23d. LOCATION (City or town) (County) (State) OAKLEY, ST. MARY'S, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY ADDRESS LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12858
12966
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dameron d. STREET ADDRESS Apt. #1 Dock's Landing Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Triplet #2 First Middle Last Regina (None) Snyder		4. DATE OF DEATH Month Day Year September 21 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. Months Days Hours Min. 24
11. BIRTHPLACE (County & State, or foreign country) St. Mary's Co. Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jack Wilfred Snyder		14. MOTHER'S MAIDEN NAME Jane Muse Stauffer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mother Address Dameron, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity. 4 mo 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1-2 min
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE Ernest D. Rehm M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 25 Sep 67
22c. PHYSICIAN'S NAME (Type) Ernest Rehm M.D.		22d. ADDRESS Lexington Park, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF SEPT. 24, 1967	23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY	23d. LOCATION (City, town or county) (State) GREAT MILLS, ST. MARY'S, Mo
24. FUNERAL DIRECTOR Mattingly's W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND		25. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR SEP 26 1967	

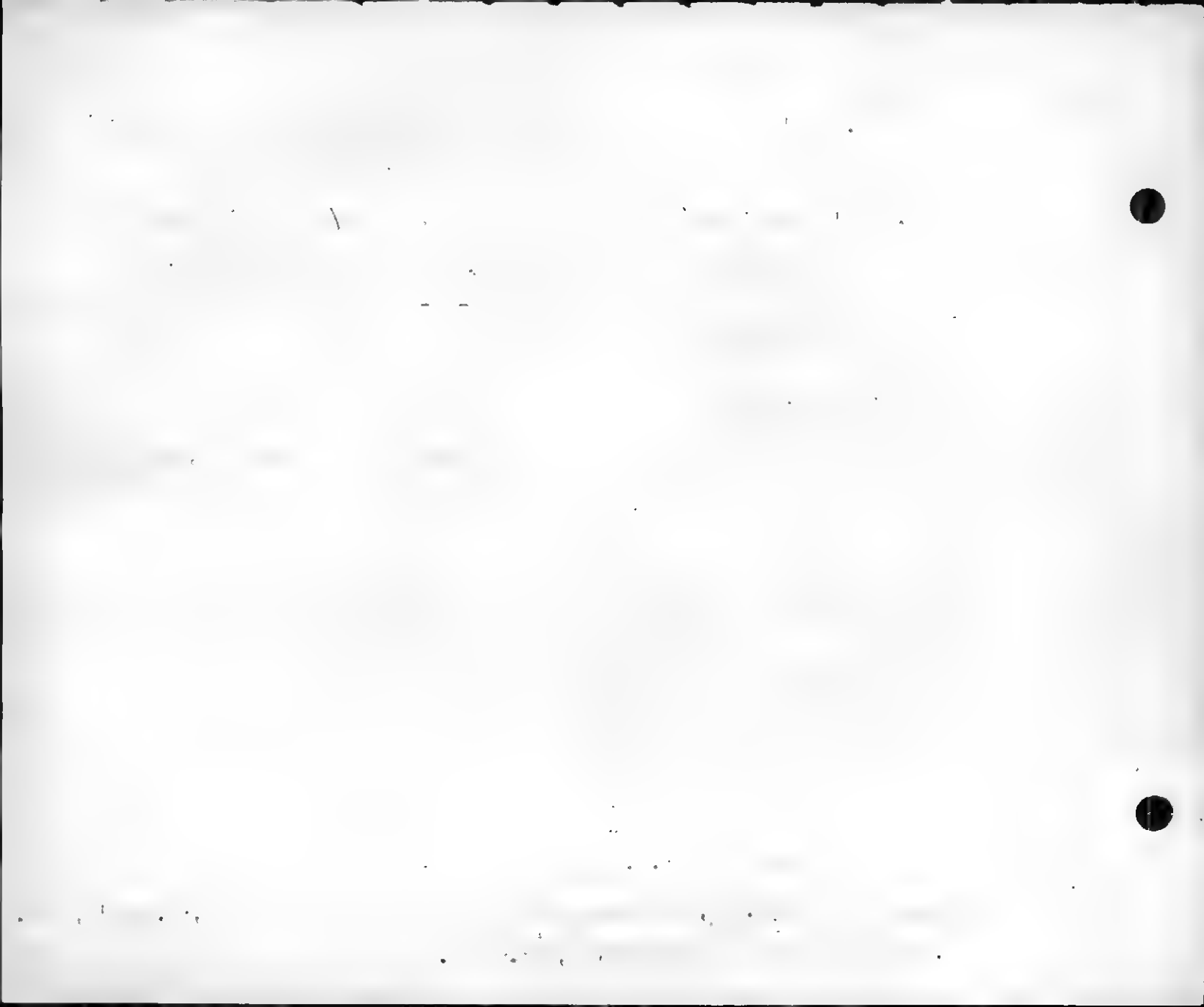


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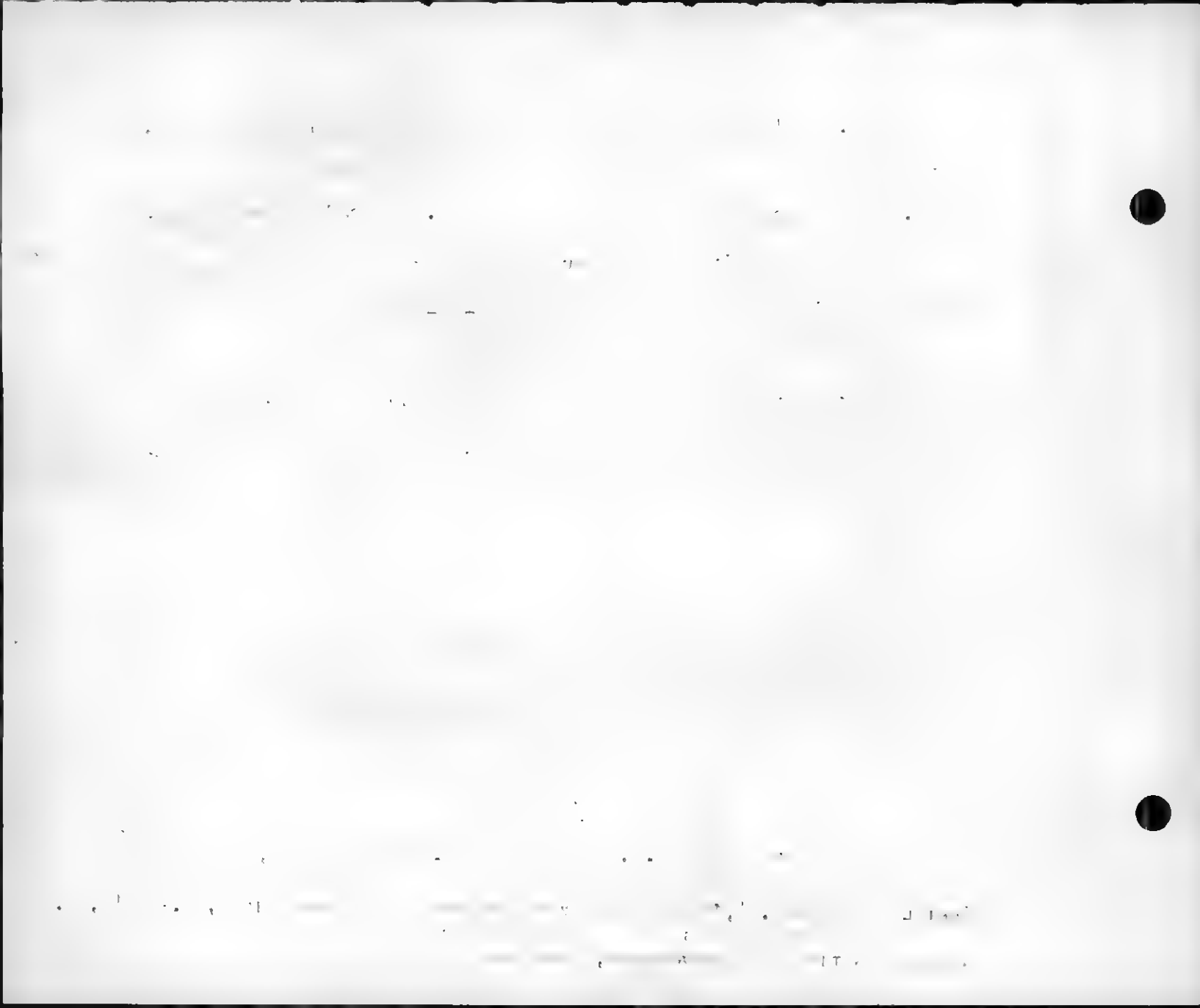
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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY 12959 <div style="text-align: center;">St. Mary's</div> <div style="text-align: right;">MARYLAND</div>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 12967 <div style="text-align: center;">Maryland</div> b. COUNTY St. Mary's					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Leonardtown</div>						c. LENGTH OF STAY IN 1b <div style="text-align: center;">Dameron</div>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center;">St. Mary's Hospital </div>						d. STREET ADDRESS <div style="text-align: center;">Apt. #1 Dock's Landing Road </div>					
3. NAME OF DECEASED (Type or print) <div style="text-align: center;"> Triplet #1 First Middle Last Richard (None) Snyder </div>						4. DATE OF DEATH Month Day Year <div style="text-align: center;"> September 21 1967 </div>					
5. SEX <div style="text-align: center;">Male</div>		6. COLOR OR RACE <div style="text-align: center;">White</div>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center;">9-21-1967</div>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <div style="text-align: center;"> — yrs. Months Days Hours Mins. </div>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">St. Mary's Co. Maryland</div>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <div style="text-align: center;">Jack Wilfred Snyder</div>						14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Jane Muse Stauffer</div>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <div style="text-align: center;"> Mother Dameron, Maryland </div>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1-2 m <div style="text-align: center;">Premature - 4 m</div> <div style="text-align: center;"> 1-16X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>										INTERVAL BETWEEN ONSET AND DEATH.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <div style="text-align: center;"> Hour a.m. p.m. 19 </div>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____ and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE 22b. DATE SIGNED <div style="text-align: center;"> Ernest D. Rehm M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Ernest Rehm M.D. Lexington Park, Maryland </div>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">BURIAL</div>						23b. DATE THEREOF <div style="text-align: center;">SEPT. 24, 1967</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">EBENEZER CEMETERY</div>		23d. LOCATION (City, town or county) (State) <div style="text-align: center;"> GREAT MILLS, ST. MARY'S, MD. </div>	
24. FUNERAL DIRECTOR <div style="text-align: center;">W. CLARKE MATTINGLEY</div>						24b. ADDRESS <div style="text-align: center;">Leonardtown, Maryland</div>		24c. REC'D BY REGISTRAR		25. REGISTRAR'S SIGNATURE <div style="text-align: center;">SEP 20 1967</div>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY St. Mary's b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown d. LENGTH OF STAY IN 1b						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dameron					
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital						d. STREET ADDRESS Apt. #1 Dock's Landing Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED Triplet #3 First Robin Middle (None) Last Snyder						4. DATE OF DEATH September 21 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-1967		9. AGE (in years last birthday) — yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
						11. BIRTHPLACE (County & State, or foreign country) St. Mary's Co. Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Jack Wilfred Snyder						14. MOTHER'S MAIDEN NAME Jane Muse Stauffer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Dameron, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - 4 mo (b) 110A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH 1-2 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Ernest D. Rehm</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 25 Sep 67			
22c. PHYSICIAN'S NAME (Type) Ernest Rehm M.D.						22d. ADDRESS Lexington Park, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF SEPT. 24, 1967		23c. NAME OF CEMETERY OR CREMATORY EBENEZER CEMETERY			23d. LOCATION (City, town or county) (State) GREAT MILLS, ST. MARY'S, MD.			
24. FUNERAL DIRECTOR Mattingly's ADDRESS Leonardtown, Md.						REC'D BY REGISTRAR SEP 26 1967		25b. REGISTRAR'S SIGNATURE			
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND											



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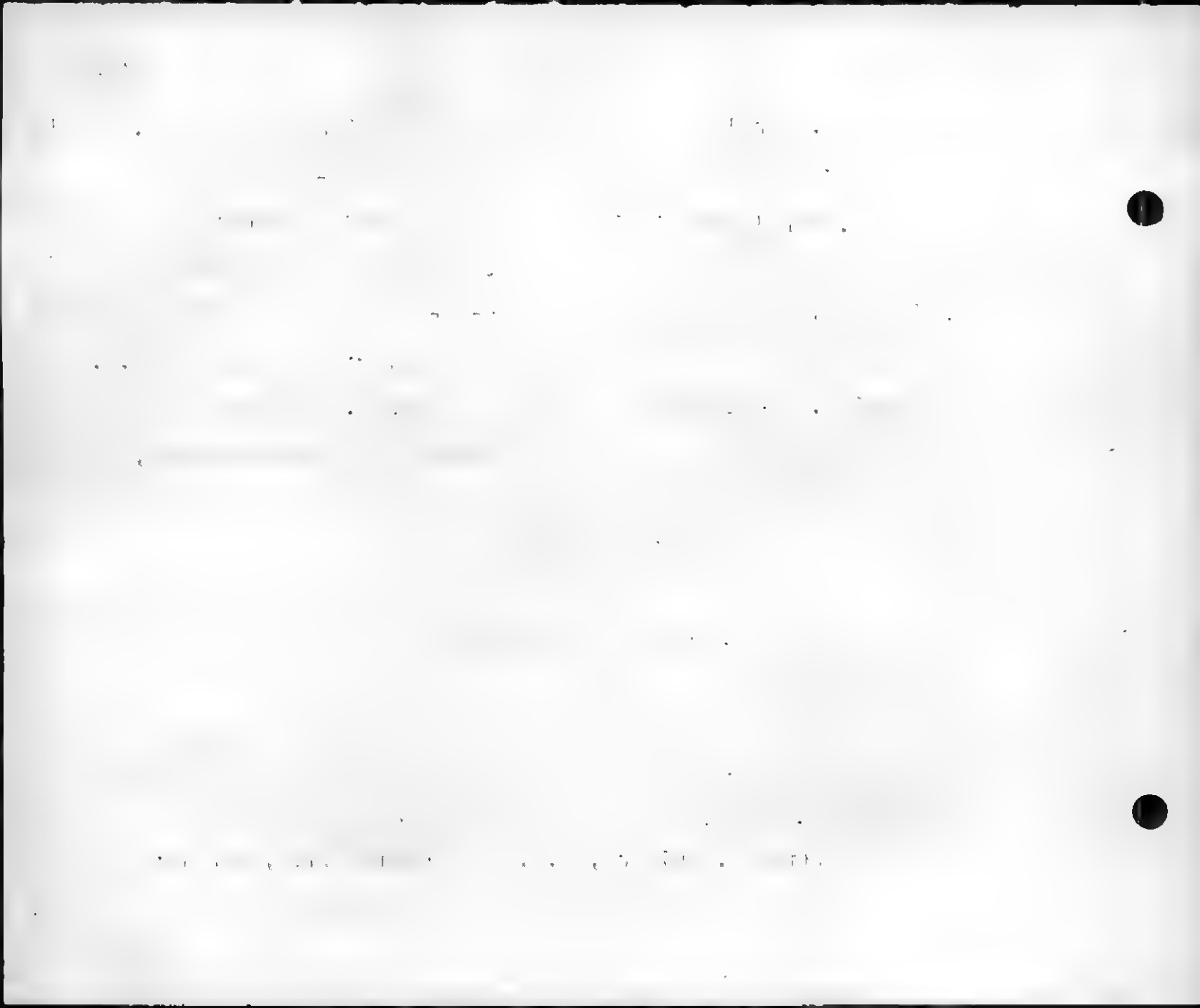
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12961											
1. PLACE OF DEATH a. COUNTY <u>ST. MARYS</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARYS</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LEONARDTOWN</u>					c. LENGTH OF STAY IN TB						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. MARYS NURSING HOME</u>					d. STREET ADDRESS						
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>MAY</u> Last <u>STEWART</u>					4. DATE OF DEATH Month <u>SEPT.</u> Day <u>6</u> Year <u>19 67</u>						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/1882</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>					16. SOCIAL SECURITY NO. <u>219 56 1162 JJ</u>		17. INFORMANT <u>MRS. RUTH STEWART - ARLINGTON, VA.</u>			Address <u>521 N. TULARD ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> <u>4231</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>atherosclerotic cardiovascular</u> (c), stating the underlying cause last. DUE TO (c)										10yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>9/1/1966</u> to <u>9/7/1967</u> , that (I) (we) last saw the deceased alive on <u>9/6/1967</u> , and that death occurred at <u>9/7/1967</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Roy Guyther</u>					M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/7/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>J. Roy Guyther</u>					22d. ADDRESS <u>MECHANICSVILLE, MARYLAND</u>						
23a. BURIAL, CREMATION, (Specify)			23b. DATE THEREOF <u>9/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State) <u>SOUTH HILLS-PITTSBURG, PA.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. WELCH</u>					ADDRESS <u>LEONARDTOWN, MARYLAND</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
					DATE <u>SEP 11 1967</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14463											
1. PLACE OF DEATH a. COUNTY St. Mary's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Mechanicsville d. STREET ADDRESS General Delivery e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Stoltzfus			4. DATE OF DEATH Month September Day 30 Year 1967								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-30-67		9. AGE (in years last birthday) yrs. 5		IF UNDER 1 YEAR Months 5 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Samuel S. Stoltzfus						14. MOTHER'S MAIDEN NAME Lydia S. Hertzler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Address Mechanicsville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Abruption placenta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prematurity - 28 weeks										INTERVAL BETWEEN ONSET AND DEATH 5 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from SEPT 29, 1967 to SEPT 30, 1967 , that (I) (we) last saw the deceased alive on SEPT 30, 1967 , and that death occurred at 12:25 AM , from the causes and on the date stated above.											
22a. SIGNATURE William C. Mulford						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) William C. Mulford, M.D.		22d. ADDRESS Mechanicsville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Oct. 1, 1967		23c. NAME OF CEMETERY OR CREMATORY Stoltzfus Cemetery			23d. LOCATION (City, town or county) (State) Mechanicsville, Md.			
24. FUNERAL DIRECTOR W. Clarke Mattingley						25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 16 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

12963

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14466

1. PLACE OF DEATH o. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN			c. LENGTH OF STAY IN 1b 12 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS ROUTE 2 Box 46		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH LUCY TIPPETT				4. DATE OF DEATH Month Day Year SEPT. 30, 19 68			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 26, 1905		9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FRANK MORGAN				14. MOTHER'S MAIDEN NAME IDA MORGAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT JOE, RAYMOND TIPPETT Address SAME AS # 2 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Acute congestive failure DUE TO (b) arterio sclerotic heart disease DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes ; Phlebitis, Bleeding peptic ulcer						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1949 , to Sept 30 1967 , that (I) (we) last saw the deceased alive on Sept 30 1967 , and that death occurred at 4 P M, from causes and on the date stated above.							
22a. SIGNATURE W.D. Boyd				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-4-67	
22c. PHYSICIAN'S NAME (Type) WILLIAM D BOYD		22d. ADDRESS LEONARDTOWN Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCTOBER 4, 1967		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY		23d. LOCATION (City or Town) (County) (State) BUSHWOOD, ST. MARY'S, MARYLAND	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE OCT 9 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

October 1, 1967

Director, Federal Bureau of Investigation

Washington, D.C.

Dear Sir:

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,

WJH

100-441100

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM contains information regarding the activities of the [redacted] in the [redacted] area. This information was obtained from a confidential source who has provided reliable information in the past. The source has advised that the [redacted] is currently active in the [redacted] area and is planning to conduct further activities in the near future. It is recommended that the Bureau be kept advised of any further information received from this source.

Very truly yours,

WJH

WJH

Very truly yours,

WJH

WJH

Very truly yours,

WJH

WJH

Very truly yours,

WJH

WJH

Very truly yours,

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WJH

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12964

CERTIFICATE OF DEATH

12970

1. PLACE OF DEATH a. COUNTY ST. MARY'S MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LEONARDTOWN		c. LENGTH OF STAY IN 1b 6 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL LEONARDTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ST. MARY'S HOSPITAL				d. STREET ADDRESS MEDLEY'S NECK		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PHILIP FRANCIS XXXXXXXX YOUNG				4. DATE OF DEATH Month SEPTEMBER Day 20 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1887		9. AGE (In years lost birthday) yrs. 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ST. MARY'S, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT YOUNG				14. MOTHER'S MAIDEN NAME MARTHA LEE WILLIAMS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 217-36-6746		17. INFORMANT JOS. PHILIP YOUNG Address LEONARDTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-vascular disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/15, 1959 to Sept 20, 1967 that (I) (we) last saw the deceased alive on Sept 27, 1967 and that death occurred at 3:15 M, from causes and on the date stated above.							
22a. SIGNATURE Charles Greenwell M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CHARLES GREENWELL M. D.				22d. ADDRESS LEONARDTOWN, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 23, 1967		23c. NAME OF CEMETERY OR CREMATOR OUR LADYS CHAPEL		23d. LOCATION (City or Town) (County) (State) MEDLEY'S NECK, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND				25a. REC'D BY REGISTRAR DATE SEP 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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